Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Carl Forrester, a prisoner at HMP Exeter, on 13 November 2024

## A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE


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1. Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In November 2024, Mr Carl Forrester was sentenced to 21 years imprisonment for sexual offences. He died of metastatic renal carcinoma (kidney cancer that spread to other parts of the body) on 13 November 2024, at HMP Exeter. He was 71 years old. We offer our condolences to Mr Forrester's family and friends.

4. The Ombudsman's office wrote to Mr Forrester's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our communication.

5. The PPO investigator investigated the non-clinical issues relating to Mr Forrester care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Forrester's clinical care at Exeter.

7. The clinical reviewer concluded that the clinical care Mr Forrester received at Exeter was of a good standard and equivalent to that which he could have expected to receive in the community. He found that Mr Forrester's medical records contained evidence of a good standard of end of life care planning. However, the clinical reviewer also found that Mr Forrester was not referred for an ultrasound, blood or urine tests at the earliest opportunity. He also concluded that Mr Forrester's persistent anaemia and raised platelet count should have been investigated.

8. We make the following recommendations:

   **The Head of Healthcare should ensure that appropriate referrals occur in a timely manner and that there is a process to ensure referrals are actioned.**

   **The Head of Healthcare should ensure that all clinical staff understand and act on local and national guidelines regarding the significance of an elevated platelet count in combination with unexplained anaemia.**

9. The initial report was shared with HM Prison and Probation Service (HMPPS) and Oxleas NHS Foundation Trust. They drew our attention to a name which had been misspelled in the clinical reviewer's report, which has now been amended, but did not point out any other factual inaccuracies.

**Adrian Usher** **May 2025**
**Prisons and Probation Ombudsman**

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